APPLICATION FOR ARIZONA RESIDENTS

For your convenience we have provided an application form for you to download.

Download and print the form.
Complete the form and have it signed by a competent authority, as defined in the eligibility requirements.
Mail the form to:

Arizona State Braille and Talking Book Library
1030 N. 32nd Street
Phoenix, AZ 85008

We cannot accept applications that are faxed to us or sent electronically.

APPLICATION FOR FREE LIBRARY SERVICE

Mr./Mrs./Ms. _____

Address _____

City _____ State _____Zip+4 _____

Telephone_____ Email Address _____

Date of Birth _____ ☐ Female ☐ Male

• By Law, preference in lending of books and equipment is given to veterans. Please check here if you have been honorably discharged from the armed forces of the United States.

PLEASE CHECK THE QUALIFYING DISABILITY:

☐ Vision loss, with correction and regardless of optical measurement, is certified by a competent authority as preventing the reading of standard printed material.

☐ Visual acuity, as determined by a competent authority, is 20/200 or less in the better eye with correcting glasses, or whose widest diameter of visual field subtends an angular distance no greater than 20 degrees.

☐ Unable to use standard printed materials as a result of physical limitations.

☐ Reading disability resulting from organic dysfunction and of sufficient severity to prevent their reading of printed material in a normal manner.

In cases of blindness, vision loss or physical limitations, "competent authority" is defined to include doctors of medicine or osteopathy, ophthalmologists, optometrists, registered nurses, therapists and the professional staff of hospitals, institutions, and public or welfare agencies.

In the absence of any of these, certification may be made by professional librarians or by any person whose competence under specific circumstances is acceptable to the Library of Congress.

In the case of reading disability from organic dysfunction, competent authority is defined as doctors of medicine or osteopathy, who may consult with colleagues in associated disciplines.

The visual or physical disability may be either temporary or permanent.

CONTACT PERSON LIVING AT ANOTHER ADDRESS:

Name_____ Telephone ( ) _____
Please Print

Street Address_____

City _____ State _____ Zip _____

TO BE COMPLETED BY CERTIFYING AUTHORITY:

I certify that the applicant named has requested library service and is unable to read or use standard printed material for the reason indicated above.

Name_____ Date _____
Please Print

Title and Occupation _____

Street Address_____ Telephone ( ) _____

City _____ State _____ Zip _____

Signature of Certifying Authority _____